STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155630	A. BUILDING 00 B. WING	06/24/2011

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FLATROCK RIVER LODGE	904 EAST 11TH STREET RUSHVILLE, IN46173

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: June 20, 21, 22, 23, and 24, 2011 Facility number: 001126 Provider number: 155630 AIM number: 200011300 Survey team: Barbara Gray RN TC Sharon Lasher RN Leslie Parrett RN Angel Tomlinson RN (June 20, 21, 22, and 23, 2011) Census bed type: SNF: 9 NF: 38 Residential: 12 NCC: 7 Total: 66 Census payor type: Medicare: 9 Medicaid: 38 Other: 19 Total: 66 Sample: 14	F0000	Preparation and execution of this plan of correction does not constitute admission or agreement by this facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies.The Plan of Correction is prepared and executed soley because the provisions of federal and state law require it. The facility maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of residents nor are they of such character as to limit the facility's capacity or render adequate care. This Plan of correction shall constitute this facility's credible allegation of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 6/29/11 Cathy Emswiller RN			
F0157 SS=D	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.			

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	Based on interview and record review the facility failed to notify the physician and family of two residents that acquired pressures ulcer at the facility for 2 of 6 residents sampled for pressure ulcers in a total sample of 14 (Resident #43 and Resident #23). Findings include: 1.) Review of the record of Resident #43 on 6-20-11 at 12:45 p.m., indicated the resident's diagnoses included, but were not limited to, Cerebral Vascular Accident (CVA) (stroke), breast cancer with met's (spread) to the lymph nodes and spine/bone, diabetes mellitus and left hemiplegia. The pressure sore, stasis ulcer and other skin sheet dated, 6-6-11, for Resident #43 indicated the resident acquired a stage II pressure ulcer at the facility on her left buttock, measuring 1 cm by 0.6 cm. The area was purple and red. The treatment was Calmoseptine every shift and as needed. There was documentation of the pressure ulcer on the resident's coccyx until 6-13-11, pressure sore stasis ulcer and other skin sheet that indicated the resident had acquired the area on 6-6-11. The physician order for Resident #43 dated, 6-7-11, indicated the resident was	F0157	The facility does notify the physician and family of residents that acquire pressure ulcers at the facility.Treadment orders for Resident #43 open areas were clarified on 6-20-11. The resident and the resident's family received notification of the change in MD orders on 6-20-11.The facility DON or designee will review medical records of all current residents for changes in status or condition as defined in 483.10(b)(11). The DON or designee shall ensure the notification of parties is completed and documented as required.CNA staff shall document and immediately report any skin irregularities to the nurse and document the observations on the CNA sheets.24 Hour Report and CNA assignment sheets will be reviewed daily by the ID team to ensure resident skin conditions changes are identified, and communicted to parties as required...The MD and family notification protocols have been reviewed and are consistent with current accepted standards of practice. Licensed nursing staf and the ID team shall be inserviced on notification requirements (F-157) The DON or designee shall monitor for compliance by conducting audits weekly for 8 weeks then monthly for 4 months to ensure continued compliance. Negative findings will be reported to the QA committee. Monitoring by Administrator and	07/24/2011

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	to have Calmoseptine every shift and as needed to coccyx. There was no physician order for the treatment of the pressure ulcer on the left buttocks, until 6-20-11. The nursing progress notes for Resident #43 dated, 6-8-11, indicated the resident had a stage II pressure sore on the left buttock, measuring 1 cm by 0.6 cm. There was no documentation of the pressure ulcer on the resident's coccyx. The pressure sore, stasis ulcer and other skin sheet dated, 6-13-11, indicated the resident acquired a stage II pressure ulcer on the coccyx in the facility on 6-6-11, measuring 1.5 cm by 1 cm. The treatment was Calmoseptine every shift and as needed. The resident's pressure ulcer on the left buttock measured 2.4 cm by 0.5 cm. Interview with RN #1 on 6-20-11 at 2:40 p.m. indicated she was unable to find an treatment order for Resident #43's pressure ulcer on the left buttock except for one dated for 6-20-11. RN #1 provided a telephone order dated, 6-20-11 at 1:50 p.m. for Resident #43 that indicated the resident was ordered Calmoseptine to coccyx open area every shift and as needed and ordered Calmoseptine to left buttock every shift and as needed until healed.		DON Completion by 7-24-11	

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	Interview with the wound nurse on 6-20-11 at 2:45 p.m., indicated the facility had been treating both of Resident #43's pressure ulcers with Calmoseptine. The wound nurse indicated she thought the physician had wrote an order for both area's, but he did not. The wound nurse indicated she did not usually do Resident #43's treatment, that LPN #5 did. The wound nurse indicated she was not sure what happened and felt that it was an miscommunication. Interview with the Director Of Nursing (DON) on 6-21-11 at 3:00 p.m. indicated there was no documentation of the physician or family notification of Resident #43's pressure ulcers on 6-6-11. The DON indicated there was documentation of the physician or family notification of Resident's pressure sore on the left buttock getting larger on 6-13-11. The DON indicated the wound nurse was responsible to notify the physician about pressure ulcers. The DON indicated if the wound nurse was not working then the another nurse would. The DON indicated whoever received an treatment order for pressure ulcers would notify the family. 2.) Review of the record of Resident #23 on 6-22-11 at 12:05 p.m., indicated the resident's diagnoses included, but were			

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	not limited to, debility, dementia and anemia. The MDS assessment for Resident #23 dated, 6-9-11, indicated the following: bed mobility- total dependence of one person, transfer- total dependence of one person, walk in room- did not occur, personal hygiene- total dependence of one person,urinary continence- frequently incontinent and bowel continence- frequently incontinent. The pressure sore, wound, stasis ulcer skin sheet for Resident #23 dated, 6-13-11, indicated the resident acquired an stage II pressure ulcer on the left buttock at the facility measuring 1.3 cm by 0.6 cm, the area was red with granulation. The treatment was Baza clear three times a day and as needed. There was no documentation the physician was notified or a treatment ordered by the physician. The physician order dated 6-16-11 indicated Resident #23 was ordered sween cream to left buttock pressure area every shift. Interview with the DON on 6-23-11 at 1:05 p.m. when queried about Resident #23 receiving Baza cream to the left buttock and no documentation of the			

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resident's physician or family being notified of the pressure ulcer on 6-13-11, the DON indicated the facility got a physician order for treatment of the resident's pressure ulcer on 6-16-11. This indicated the facility was applying Baza cream for 3 day prior to obtaining a physician order for the treatment of Resident #23'S pressure ulcer.

The facility "Skin Treatment Management Protocol" provided by the Administrator on 6-22-11 at 2:30 p.m., included, but were not limited to, the following: An stage II pressure ulcer is partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. The treatment protocol is notify the physician/obtain orders/diagnosis. Notify the Power Of Attorney (POA)/Legal representative. Notify the wound nurse and person at risk committee and 24 hour report entry. Re-evaluate/implement prevention interventions.

The "Change in Resident's Condition/Status: Resident, Physician and Family/Legal Representative Notification/Consultation" policy provided by the Administrator on 6-22-11 at 2:30 p.m., indicated the purpose was the facility will promptly notify the resident, the resident's attending physician

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	and the resident's legal representative or interested family member of changes in the resident's condition and/or status. 3.1-5(a)(2)			
F0279 SS=D	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on interview and record review the facility failed to develop an plan of care to	F0279	The facility does develop a plan of care to prevent urinary track infection for residents with a	07/24/2011

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	prevent urinary tract infections for a resident with an history of urinary tract infections for 1 of 5 sampled for urinary tract infections in a total sample of 14 (Resident #43). Finding include: Review of the record of Resident #43 on 6-20-11 at 12:45 p.m., indicated the resident's diagnoses included, but were not limited to, history of urinary tract infection. The nursing progress notes for Resident #43 dated, 5-23-11 at 1:24 p.m., indicated the physician was contacted due to the resident had a change in condition. The residents had a temperature of 101.3, chills and seeing people who were not there. The physician gave an order to send the resident to the emergency room for an evaluation and treatment. The local hospital emergency room record for Resident #43 dated, 5-23-11, indicated the resident had a urinary tract infection. The resident was given Cipro (antibiotic) Intravenously (IV). Review on 6-20-11 at 12:45 p.m., of Resident #43's plan of care dated from 3-14-11 to 6-3-11, indicated there was no plan of care to prevent urinary tract		history of urinary track infections. Resident #43 Care Plan was immediately updated to include plan of care interventions to prevent urinary track infections.An MDS audit for all residents with a history of UTI will be completed. At risk residents care plans will be updated, as may be necessary, to prevent urinary tract infections. The DON will review care plans and care plan updates to ensure those at risk for urinary tract infections have a care plan in place. This will be done weekly for eight weeks then monthly for four months. Any negative findings will be reorted to QAThe administrator shall monitor for compliance by reviewing nursing notes, 24 hour report sheets and CNA assignment sheets.Monitored by Administrator and DON	

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	infections. Interview with RN #1 on 6-20-11 at 1:55 p.m., indicated there was no plan of care developed for Resident #43 to prevent further urinary tract infections. RN #1 indicated she was unsure why there was not, but she would develop one at this time. 3.1-35(a)			
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and record review, the facility failed to follow a resident's plan of care to keep the foot drop and wheelchair legs padded with sheepskin, in the total sample of 14. (Resident #34) Findings Include: Resident #34's record was reviewed on 6/21/11 at 10:25 A.M. Diagnoses included but were not limited to anorexia, anemia, osteoporosis, osteoarthritis, and fragile skin.	F0282	The facility does provide services by qualified persons in accordance with each residents written plan of care.Resident's #34 wheelchair leg and foot drop was immeditely padded with sheepskin. The CNA assignment sheet was updated.All CNA assignment sheets will be audited with all care plans for accuracy and checked after any update for accuracy.Resident #34's includes the sheepskin intervention on the care plan. The sheep skin was placed on chair on 6-22-11.The MDS coordinator will ensure all CNA care plan items are on the assignment sheet (care Plan). All	07/24/2011

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	Resident #34's significant change Minimum Data set assessment dated 3/31/11, indicated the following: Resident #34 made herself understood and usually understood others,her cognitive skills for daily decision making were moderately impaired, she required total dependence of 2 persons for transfers, she did not walk, she used a wheelchair, she had no functional limitation in range of motion in her upper or lower extremities, and she was on Hospice care. A care plan for Resident #34 dated 3/14/11, indicated the following: Problem - Potential for tissue integrity impairment. Related to - decreased mobility, bowel incontinence, fragile skin, and history of skin tears. Approach - Keep foot drop and wheel chair legs padded with sheepskin. Nurses notes for Resident #34 indicated the following: 2/2/11 - Skin tear to right shin re-opened. Pink in color with blood noted on the old dressing. Adaptic to right shin, change every 3 days. 2/10/11 - Skin tear to left shin re-opened, 2 centimeters (cm) by 1 cm. Small amount of blood on old dressing. Adaptic to right and left shin tears. Change every 3 days and as needed. 5/11/11 - Skin tear to left shin measuring 2.3 cm by 1.6 cm.		staff that perform services were qualified in all criteria. Other residents with identified need for chair padding were reviewed. CNA assignment sheets were reviewed to ensure they contain planned interventions. The administrator shall monitor for compliance by reviewing nursing notes, 24 hour report sheets and CNA assignment sheets. The DON will review all cna assignment sheets with care plan updates weekly for the next eight weeks and monthly for the next four months to ensure interventions for those at risk for skin tears are on the CNA assignment sheet. Any negarive finding will be reported to QA.Monitored by Administrator and DON	

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	Treatment of Adaptic and change every 3 days. 6/14/11 - Skin tear to residents right lower calf measuring 0.5 cm by 1 cm. Adaptic placed and wrapped. Physician's orders for resident #34 indicated the following: 1/31/11 - Adaptic dressing to right lower leg skin tear. Cover with gauze until healed. 5/6/11 - Adaptic to left leg skin tear. Change every 3 days until healed. 6/15/11 - Adaptic to right lower calf skin tear, measuring 0.5 centimeters(cm) by 1 cm. Cover with Kerlix, change every 3 days, and as needed. Resident #34 was observed seated in her wheelchair on 6/20/11 at 2:12 P.M. Resident #34's bilateral legs had continuous movement while they rested on the wheelchair's elevated bilateral foot and leg rests, with an attached foot drop board. Resident #34 had gauze wrapped around her left lower leg dated 6/20/11. Resident #34 indicated she had skinned her leg and foot. No sheepskin was present on Resident #34's wheelchair legs or foot drop board. Resident #34 was observed being transferred from her wheelchair to her bed on 6/21/11 at 10:08 A.M. Prior to transfer, Resident #34's bilateral legs were elevated on the wheelchair's bilateral			

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	leg and foot rests, with an attached foot drop board. No sheep skin was present on Resident #34's wheelchair legs or foot drop board. Resident #34 was observed seated in the dining room in her wheelchair on 6/22/11 at 11:42 A.M. Resident #34's bilateral legs were elevated on the wheelchair's bilateral leg and foot rests, with an attached foot drop board. No sheepskin was present on Resident #34's wheelchair legs or foot drop board. Resident #34 was observed being transferred from her wheelchair to her bed on 6/22/11 at 2:20 P.M. Prior to transfer, Resident #34's bilateral legs were elevated on the wheelchair's bilateral leg and foot rests, with an attached foot drop board. No sheepskin was present on Resident #34's wheelchair legs or foot drop board. An interview with the Director of Nursing (DoN) on 6/22/11 at 4:03 P.M., indicated Resident #34 had a physician's order for Lac-Hydrin lotion because her skin was dry and tore easily. The DoN indicated Resident #34 should have had sheepskin on the outside metal of her wheelchair leg rest but did not. The DoN indicated she could not find any sheepskin in Resident #34's bedroom.			

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	A CNA care assignment sheet for Resident #34 provided by Medical Records staff #7 on 6/23/11 at 9:28 A.M., did not indicate to keep her foot drop and wheelchair legs padded with sheepskin. Medical Records staff #7 indicated the sheepskin was added on Resident #34's CNA assignment sheet on 3/23/11, and when supportive devices were updated on 5/3/11, supportive devices from 3/23/11 dropped off, and should not have. 3.1-35(g)(2)			
F0314 SS=D	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview and record review the facility failed to put interventions in place to prevent pressure	F0314	The facility does put interventions in place to prevent pressure ulcers, to initiate treatment ordered by the physician and to	07/24/2011

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	ulcers, to initiate treatment ordered by the physician and to identify 5 open areas for 3 of 6 residents reviewed for pressures ulcers in a sample of 14. (Resident #44, #43 and #23) Findings include: 1.) On 6/22/11 at 11:35 a.m. staff CNA #2 and staff CNA#3 were observed providing a transfer from the wheelchair to the bed with the hoyer lift and during interview at that time, CNA #3 indicated Resident #44 did not have a cushion in her wheelchair. Incontinence care for Resident #44 was provided and the following open areas were observed: - open area at middle abdomen below the umbilicus (navel), approximately 4 cm (centimeters) long .3 cm wide, linear shaped, red in the center, surrounding skin no change in color and no drainage - open area on the coccyx, approximately 2 cm x .3 cm, linear shaped, red in the center, surrounding skin no change in color and no drainage - open area on the right inner thigh approximately 6 cm x 1.0 cm wide, linear shaped, red in the center, surroundings skin no change in color and no drainage - open area on the right inner thigh next to the approximately 6 cm open area, 2 cm long x .3 cm wide, linear shaped, red in		identify open areas. Resident #23's Dr. and family notified on 6-16-11. An MD order for treatment was received on 6-16-11. All CNA and nursing staff were retrained to edentify and document newly identified skin conditions per policy. Inservices will be given to all license staff on Physican Notification, and Skin Treatment Management Protocol. Resident #44 was reassessed. The care plan shall be updated to reflect all current skin conditions, risk factors for impaired skin integrity, and interventions for management. Resident #43 was observed on an air mattress on 6-20-11 at 12:30 pm. The alternating pressure air mattress itself is a pressure reducing device. Resident #43's care plan shall be updated to reflect all current skin conditions, risk factors for impaired skin integrity, and interventions for management. Appropriate MD orders shall be obtained as necessary. Treatment orders for Resident #43 open areas were clarified on 6-20-11. The resident and the Resident's family received notification of the change in MD orders. Resident care plans shall be updated to reflect all current skin conditions, risk factors for impaired skin integrity, and interventions for management. Appropriate MD orders shall be obtained as necessary. The DON shall	

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	center, surrounding skin no change in color and no drainage - open area on the left upper buttock, approximately .5 cm x .4 cm oval shaped, red in center, surrounding skin no change in color and no drainage The record of resident #44 was reviewed on 6/22/11 at 10:35 a.m. Resident #44's diagnoses included but were not limited to dementia, obesity, Alzheimer's disease, hyponatremia (low sodium), diabetic and anemia. Resident #44's Minimum Data Set (MDS), assessment, dated 6/10/11 indicated the following: - makes self understood, usually understood - ability to understand others, usually understands - bed mobility, extensive assistance, with 2 plus physical assist - transfer, total dependence, with 2 plus physical assist - walk in room or corridor, activity did not occur - urinary continence, frequently incontinent - bowel continence, frequently incontinent - risk of pressure ulcer, yes - unhealed pressure ulcers, yes - current number of unhealed pressure ulcers at each stage		conduct weekly skin rounds for eight weeks to ensure treatments, MD orders and care plans are appropriate and consistent with facility skin management protocols.CNA staff shall immediately report any skin irregularities to the nurse and document the observations on the CNA assignment sheets.The DON will review all new care plan and care plan updates weekly for the next eight weeks and monthly for the next four months to ensure those at risk for skin breakdown have a care plan in place. Any negartive finding will be reported to QAThe administrator shall monitor for compliance by reviewing nursing notes, 24 hour report sheets and CNA assignment sheets. Monitored by Administrator and DON	

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	- stage 1, 1 - number of stage 2 pressure ulcers, 3 - date of oldest stage 2 pressure ulcer, 6/6/11 Resident #44's physician's orders on the treatment sheets, dated, 6/11, indicated " Nystop powder (yeast infection), apply topically to abdominal, fold twice daily, Nystatin (yeast infection) 1% cream every shift and as needed until healed to inner thighs, peri area and buttock, vitamin A & D ointment, apply topically to knees, twice a day and left shin open area, clean with wound cleaner and apply duodenum every 3 days until healed." Resident #44's care plan dated, 6/14/11, indicated the following: "Problem, at risk for further skin pressure areas. Tissue tolerance time = every hour to 1 and 1/4 hours approximately. Has skin pressure area on left knee, left inner shin and left outer shin. Approach, turning and repositioning every hour to 1 and 1/4 hour approximately, daily every shift while in bed and wheelchair. Cue to self help as she is able with assist of 1 or 2 depending on her ability at given time. Monitor and report skin issues to nurse as needed. Use appropriate pillows to keep resident comfortable in different positions. Has a pressure relieving mattress on her bed. Use lift sheet as needed to assist with			

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	turning while in bed. Goal, To prevent further skin pressure issues as evidence by resident will be repositioned throughout each shift daily while in bed and wheelchair and will show improvement with skin pressure areas on left knee, left inner shin and left outer shin by next assessment. Resident #44's "skin condition management report" indicate area affects, left knee, date of origin present on admission, 6/6/11, stage 2, size cm, 0.5 cm x 1.9 cm, yellow/red. The "skin condition management report" dated, 6/21/11, lacked documentation except for the left knee, stage 2, skin ulcer. Interview with the Director of Nursing (DON) on 6/22/11 at 3:10 p.m., indicated the 5 open areas observed today were not open until today and she did not have the open areas yesterday because the DON looked at the CNA assignment sheets and the 24 hour report and nothing was documented. She also indicated we have been treating her red excoriated areas from inner thighs, peri area and buttocks with nystop powder. Resident #44's nursing notes indicated the following:			

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	- 6/22/11 at 4:03 a.m., general skin condition, skin color adequate cool to touch and dry has treatment to areas of skin per MD orders. Skin color adequate cool to touch and dry has treatment to areas of skin per MD orders. - 6/22/11 at 2:59 p.m., weekly skin assessment, resident has excogitation in peri-area. Bruises are noted on arms and body that have been present and are fading. Resident had blisters that are resolving. New open areas were noted today on Thighs. Treatment nurse notified. - 6/22/11 at 3:37 p.m., skin problem, resident with new areas noted today. 1.) Abdomen 4.2 cm x 0.3 cm, stage 2, red with no drainage or odor noted, granulation tissue present. 2.) Right inner upper thigh 6 cm x 0.8 cm stage 2, red with no drainage or odor noted, granulation tissue present. 3) Right inner lower thigh 1.5 cm x 0.3 cm, stage 2, red with no drainage or odor noted, granulation tissue present. 4.) Coccyx 1.5 cm x 0.2 cm, stage 2, red with no drainage or odor noted, granulation tissue present. 5.) Left buttock 0.6 cm x 0.4 cm, stage 2, red with no drainage or odor noted, granulation tissue present. #2) During observation on 6-20-11 at 12:30 p.m., Resident #43 was eating lunch in her bed. Resident #43 bed was on an air mattress and the resident did not			

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	have on pressure relieving boots on either foot. An pressure relieving boot was laying on the resident's love seat. During interview at that time Resident #43 indicated that she does wear the boot sometimes. Review of the record of Resident #43 on 6-20-11 at 12:45 p.m. indicated the resident was admitted to the facility on 3-14-11. The resident's record reviewed on 6-20-11 at 12:45 p.m., indicated Resident #43's diagnoses included, but were not limited to, Cerebral Vascular Accident (CVA) (stroke), breast cancer with met's (spread) to the lymph nodes and spine/bone, diabetes mellitus and left hemiplegia. The local hospital notes for Resident #43 dated, 3-11-11 indicated the resident had an open to air wound on the achilles portion on her left heel, which was healing. Patient is at risk for skin breakdown and nursing monitors wound, skin integrity and signs and symptoms of infection and further skin breakdown. The continuity of care record from the local hospital for Resident #43 dated, 3-14-11, indicated left heel allevyn dressing.			

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	The nursing progress notes for Resident #43 dated, 3-14-11 at 8:37 p.m. indicated the resident was a new admission. The resident's "skin is pale in color, warm and dry." The resident requires a hoyer lift and two people to transfer. The resident requires 1 or 2 staff for bed mobility. The nursing progress note for Resident #43 dated, 3-14-11 at 9:37 p.m., indicated the resident's mobility was very limited. The resident occasional made slight changes in body/extremity position. The resident cannot make frequent and significant changes alone. The resident moves with minimal assist and has some sliding with repositioning. The resident occasionally slides down in the bed and chair. The resident is bedfast and confined to bed. The physician orders for Resident #43 dated, 3-14-11, indicated no treatment order for the resident's left heel. The care plan for Resident #43 with a problem date of 3-24-11 indicated the resident was unable to reposition self in bed, related to left sided weakness secondary to CVA. The intervention dated 5-13-11 indicated "foam foot support to be on only when resident is in bed , float left heel off of bed. The intervention dated 6-14-11 indicated the resident was on a			

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	turning and repositioning program every hour daily, every shift. The physician telephone order for Resident #43 dated, 5-6-11, indicated Resident #43 had a stage one pressure area to the left heel measuring 1.4 centimeter (cm) by 2 cm. "May we have order for A & D TID (three times a day) until healed." "Also elevated (L) heel while in bed until area healed." The physician response was "yes". The Minimum Data Set (MDS) assessment for Resident #43 dated, 5-12-11, indicated the following: bed mobility- extensive assistance of two people, transfer- total dependence of two people, walk in room- did not occur, personal hygiene- extensive assistance of one person, unhealed pressure ulcer-yes, number of stage 1 pressure- 1. The pressure sore, stasis ulcer and other skin sheet dated, 5-9-11, for Resident #43 indicated the following: the resident acquired a stage 1 pressure ulcer at the facility on 5-6-11 measuring 1.4 cm by 2 cm, it was purple in color, the skin was intact and the treatment was A&D three times a day and elevate heel until healed. The pressure sore, stasis ulcer and other skin sheet dated, 5-16-11, for Resident			

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	#43 indicated the following: the resident's left heel pressure ulcer measured 1 cm by 1 cm. The pressure sore, stasis ulcer and other skin sheet dated, 5-23-11, for Resident #43 indicated the following: the resident's left heel pressure ulcer was healed. The pressure sore, stasis ulcer and other skin sheet dated, 6-6-11, for Resident #43 indicated the resident acquired a stage II pressure ulcer at the facility on her left buttock, measuring 1 cm by 0.6 cm. The area was purple and red. The treatment was Calmoseptine every shift and as needed. There was documentation of the pressure ulcer on the resident's coccyx. The physician order for Resident #43 dated, 6-7-11, indicated the resident was to have Calmoseptine every shift and as needed to coccyx. There was no physician order for treatment of the pressure ulcer on the left buttocks. The nursing progress notes for Resident #43 dated, 6-8-11, indicated the resident had a stage II pressure sore on the left buttock, measuring 1 cm by 0.6 cm. There was no documentation of the pressure ulcer on the resident's coccyx. The pressure sore, stasis ulcer and other			

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	skin sheet dated, 6-13-11, indicated the resident acquired a stage II pressure ulcer on the coccyx in the facility on 6-6-11, measuring 1.5 cm by 1 cm. The treatment was Calmoseptine every shift and as needed. The resident's pressure ulcer on the left buttock measured 2.4 cm by 0.5 cm. During observation on 6-20-11 at 2:05 p.m., CNA #4 and CNA # 2 cleaned Resident #43's peri area. When queried if the resident was suppose to have a pressure relieving boot on her left foot. CNA #4 and CNA #2 indicated they were not sure CNA #4 indicated Resident #43 got the air mattress for her bed on Friday (6-17-11). Interview with the wound nurse at this time indicated she would find out, therapy had been working with resident to get a new boot. The wound nurse then washed her hands and applied Calmoseptine cream with a Q- tip to the resident's left buttock and coccyx. The left buttock was red with some yellow and coccyx was red and pink. The wound nurse indicated Calmoseptine was the treatment the facility was using every shift to the coccyx and buttocks. Interview with RN #1 on 6-20-11 at 2:40 p.m. indicated she was unable to find an treatment order for Resident #43's pressure ulcer on the left buttock except			

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	for one dated for 6-20-11. RN #1 provided a telephone order dated, 6-20-11 at 1:50 p.m. for Resident #43 that indicated the resident was ordered Calmoseptine to coccyx open area every shift and as needed and ordered Calmoseptine to left buttock every shift and as needed until healed. Interview with the wound nurse on 6-20-11 at 2:45 p.m., indicated the facility had been treating both of Resident #43's pressure ulcers with Calmoseptine. The wound nurse indicated she thought the physician had wrote an order for both area's, but he did not. The wound nurse indicated she did not usually do Resident #43's treatment, that LPN #5 did. The wound nurse indicated she was not sure what happened and felt that it was an miscommunication. Interview with the Director Of Nursing (DON) on 6-21-11 at 3:00 p.m. indicated there was no documentation of the physician or family notification of Resident #43's pressure ulcers on 6-6-11. The DON indicated there was documentation of the physician or family notification of Resident's pressure sore on the left buttock getting larger on 6-13-11. The DON indicated the wound nurse was responsible to notify the physician about pressure ulcers. The DON indicated if the			

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	wound nurse was not working then the another nurse would. The DON indicated whoever received an treatment order for pressure ulcers would notify the family. The DON indicated the facility had measures in place to prevent Resident #43's pressure ulcers, the DON indicated on 3-15-11 the resident was placed on an turning and repositioning schedule, on 5-6-11 the resident's left heel was to be elevated, on 5-11 the resident was to have skin assessments daily and to notify the physician of changes, on 5-13-11 the resident's skin was to be kept clean and dry and a foam foot support to left heel was added, on 6-2-11 the resident was to have appropriate pillows for comfort and different positions. Interview with the Dietary Manager on 6-21-11 at 4:00 p.m. indicated the facility had been giving Resident #43 2 eggs for added protein due to the resident's diagnosis of cancer. The Dietary Manager indicated she did not have any documentation of how long the resident had been receiving the two eggs or when it started. The dietary progress notes for Resident #43 dated from, 3-25-11 to 6-20-11, did not address the resident's pressure ulcers, until 6-20-11 at 8:44 p.m., the note indicated the following: "Risk: Stage 2			

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	pressure ulcer x 2 to coccyx and left buttock." Will request to add an multivitamin with minerals daily in addition to sugar free shake twice a day to provide additional protein and calories. 3.) Review of the record of Resident #23 on 6-22-11 at 12:05 p.m., indicated the resident's diagnoses included, but were not limited to, debility, dementia and anemia. The MDS assessment for Resident #23 dated, 6-9-11, indicated the following: bed mobility- total dependence of one person, transfer- total dependence of one person, walk in room- did not occur, personal hygiene- total dependence of one person,urinary continence- frequently incontinent and bowel continence- frequently incontinent. The pressure sore, wound, stasis ulcer skin sheet for Resident #23 dated, 6-13-11, indicated the resident acquired an stage II pressure ulcer on the left buttock at the facility measuring 1.3 cm by 0.6 cm, the area was red with granulation. The treatment was Baza clear three times a day and as needed. There was no documentation the physician was notified or an treatment ordered by the physician.			

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	The physician order dated 6-16-11 indicated Resident #23 was ordered sween cream to left buttock pressure area every shift. Interview with the DON on 6-23-11 at 1:05 p.m. when queried about Resident #23 receiving Baza cream to the left buttock and no documentation of the resident's physician or family being notified of the pressure ulcer on 6-13-11, the DON indicated the facility got an physician order for the resident's pressure ulcer on 6-16-11. This indicated the facility provided treatment to Resident #23's pressure ulcer without an physician order for 3 days. The facility "Skin Treatment Management Protocol" provided by the Administrator on 6-22-11 at 2:30 p.m., included, but were not limited to, the following: An stage II pressure ulcer is partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. The treatment protocol is notify the physician/obtain orders/diagnosis. Notify the Power Of Attorney (POA)/Legal representative. Notify the wound nurse and person at risk committee and 24 hour report entry. Re-evaluate/implement prevention interventions.			

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	3.1-40(a)(1) 3.1-40(a)(1)			
F0323 SS=D	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to have a resident's legs protected to prevent skin tears, for a resident with a history of skin tears, in that the resident's foot drop and wheelchair legs were not covered with sheepskin, and failed to follow the owners operating instructions for transferring 1 resident with an Invacare lift, for 3 residents observed for Invacare transfers, in the total sample of 14. (Resident #34). Findings Include: 1.) Resident #34's record was reviewed on 6/21/11 at 10:25 A.M. Diagnoses included but were not limited to dementia	F0323	The facility does ensure that the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents. Resident #34 wheelchair legs and foot drop pedal was immediately padded with sheepskin on 6-22-11. The CNA assignment sheet was updated. Resident #34 care plan did include the sheepskin intervention. All CNA assignmenet sheets will be audited with the care plans for accuracy and checked for accuracy after any update. The nursing staff involved in the transfer of resident #34 was immediately reeducated on the	07/24/2011

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	155630	A. BUILDING 00 B. WING	06/24/2011

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FLATROCK RIVER LODGE	904 EAST 11TH STREET RUSHVILLE, IN46173

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	with a history of paranoia, anorexia, anemia, osteoporosis, osteoarthritis, and fragile skin. Resident #34's significant change Minimum Data set assessment dated 3/31/11, indicated the following: Resident #34 made herself understood and usually understood others,her cognitive skills for daily decision making were moderately impaired, she required total dependence of 2 persons for transfers, she did not walk, she used a wheelchair, she had no functional limitation in range of motion in her upper or lower extremities, and she was on Hospice care. A care plan for Resident #34 dated 3/14/11, indicated the following: Problem - Potential for tissue integrity impairment. Related to - decreased mobility, bowel incontinence, fragile skin, and history of skin tears. Approach - Keep foot drop and wheel chair legs padded with sheepskin. Nurses notes for Resident #34 indicated the following: 2/2/11 - Skin tear to right shin re-opened. Pink in color with blood noted on the old dressing. Adaptic to right shin, change every 3 days. 2/10/11 - Skin tear to left shin re-opened, 2 centimeters (cm) by 1 cm. Small amount of blood on old dressing. Adaptic to right		operating instructions for transferring residents with the Invacare lift and counseled for failure to follow protocols. All nursing staff will be inserviced on the operating instruction for transferring residents with the lift. The DON will monitor CNA compliance for transferring residents with the Invacare lift and audit all CNA assignment sheets,for accuracy, with care plan updates. This will be done weekly for eight weeks, then monthly for four months. Any negative findings will be reported to QA Monitored by Administrator and DON	

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	and left shin tears. Change every 3 days and as needed. 5/11/11 - Skin tear to left shin measuring 2.3 cm by 1.6 cm. Treatment of Adaptic and change every 3 days. 6/14/11 - Skin tear to residents right lower calf measuring 0.5 cm by 1 cm. Adaptic placed and wrapped. Physician's orders for resident #34 indicated the following: 1/31/11 - Adaptic dressing to right lower leg skin tear. Cover with gauze until healed. 5/6/11 - Adaptic to left leg skin tear. Change every 3 days until healed.. 6/15/11 - Adaptic to right lower calf skin tear, measuring 0.5 centimeters(cm) by 1 cm. Cover with Kerlix, change every 3 days, and as needed. Resident #34 was observed seated in her wheelchair on 6/20/11 at 2:12 P.M. Resident #34's bilateral legs had continuous movement while they rested on the wheelchair's elevated bilateral foot and leg rests, with an attached foot drop board. Resident #34 had gauze wrapped around her left lower leg dated 6/20/11. Resident #34 indicated she had skinned her leg and foot. No sheepskin was present on Resident #34's wheelchair legs or foot drop board. Resident #34 was observed being transferred from her wheelchair to her bed			

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	on 6/21/11 at 10:08 A.M. Prior to transfer, Resident #34's bilateral legs were elevated on the wheelchair's bilateral leg and foot rests, with an attached foot drop board. No sheepskin was present on Resident #34's wheelchair legs or foot drop board. Resident #34 was observed seated in the dining room in her wheelchair on 6/22/11 at 11:42 A.M. Resident #34's bilateral legs were elevated on the wheelchair's bilateral leg and foot rests, with an attached foot drop board. No sheepskin was present on Resident #34's wheelchair legs or foot drop board. Resident #34 was observed being transferred from her wheelchair to her bed on 6/22/11 at 2:20 P.M. Prior to transfer, Resident #34's bilateral legs were elevated on the wheelchair's bilateral leg and foot rests, with an attached foot drop board. No sheepskin was present on Resident #34's wheelchair legs or foot drop board. An interview with the Director of Nursing (DoN) on 6/22/11 at 4:03 P.M., indicated Resident #34 had a physician's order for Lac-Hydrin lotion because her skin was dry and tore easily. The DoN indicated Resident #34 should have had sheepskin on the outside metal of her wheelchair leg			

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	rest but did not. The DoN indicated she could not find any sheepskin in Resident #34's bedroom. A CNA care assignment sheet for Resident #34 provided by Medical Records staff #7 on 6/23/11 at 9:28 A.M., did not indicate to keep her foot drop and wheelchair legs padded with sheepskin. Medical Records staff #7 indicated the sheepskin was added on Resident #34's CNA assignment sheet on 3/23/11, and when supportive devices were updated on 5/3/11, supportive devices from 3/23/11 dropped off, and should not have. 2.) Resident #34 was observed being transferred from her wheelchair to her bed on 6/21/11 at 10:08 A.M., by CNA #4 and CNA #5, with the use of a Invacare lift. CNA #4 operated the lift while CNA #5 assisted. CNA #4 opened the Invacare lift legs around Resident #34's wheelchair. The Invacare sling was attached to the lift and Resident #34 was lifted. CNA #5 moved the wheelchair backwards and CNA #4 closed the Invacare lift legs, turned the lift left, guided the lift to Resident #34's bed, and placed the lift legs under the bed. Resident #34 was lowered to her bed. An interview with CNA #4 indicated she closed the Invacare lift legs because she had more control over the lift with the legs closed. CNA #4			

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	indicated she closed the Invacare lift legs because there were wires under the bed. CNA #4 indicated Resident #34's bed would raise but sometimes the wires still hung down. An interview with CNA #4 on 6/23/11 at 9:50 A.M., indicated she was trained not to close the Invacare lift legs when transferring a resident because leaving the legs open helped balance the lift. CNA #4 indicated she automatically closed the lift legs when she placed them under a bed, then she could pull the lift legs straight out. CNA #4 stated "I just have a bad habit of doing that". Resident #34 was observed being transferred from her wheelchair to her bed on 6/22/11 at 2:20 P.M., by CNA #4 and CNA #6, with the use of a Invacare lift. CNA #6 operated the lift while CNA #4 assisted. CNA #6 opened the Invacare lift legs around Resident #34's wheelchair. The Invacare sling was attached to the lift and Resident #34 was lifted. CNA #4 moved the wheelchair backwards and raised Resident #34's bed. CNA #6 turned the lift left, guided the lift to Resident #34's bed, and placed the lift legs under the bed in the opened position. Resident #34 was lowered to her bed. CNA #6 had no difficulty placing the Invacare lift legs			

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	under Resident #34's bed in the opened position. The Invacare lift legs were not tangled in any wires. The Invacare owner and operating instructions indicated the following: Operating the patient lift WARNING -" Only operate this lift with the legs in MAXIMUM OPEN POSITION and LOCKED in place. The base legs must be locked in the open position at all times for stability and patient safety when lifting and transferring a patient". 3.1-45(a)(2)			